STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION

In the Matter of:	Case No. INS-21-0044
PACIFICSOURCE HEALTH PLANS, Respondent.	ORDER TO CEASE AND DESIST, FINAL ORDER ASSESSING CIVIL PENALTY AND CONSENT TO ENTRY OF ORDER THIS IS A FINAL ORDER

The Director of the Department of Consumer and Business Services for the State of Oregon ("Director"), acting in accordance with Oregon Revised Statutes ("ORS") chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750 ("Insurance Code"), has conducted an investigation into the insurance related activities of PacificSource Health Plans ("PacificSource" or "Respondent").

Respondent submits to the Director's jurisdiction and agrees to waive its rights to notice and an administrative hearing that arise under ORS 183.415, and, without admitting or denying the Director's Findings of Fact or Conclusions of Law, wishes to resolve this matter by consenting to entry of this Final Order.

Now therefore, as evidenced by the signatures subscribed in this Order, Respondent hereby consents to entry of this Order upon the Director's Findings of Fact and Conclusions of Law.

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350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

FINDINGS OF FACT

The Director FINDS that:

1. Respondent has been licensed by the Director, by and through the Division of Financial Regulation, previously known as the Insurance Division (collectively, the "Division"), as a health care service contractor since June 20, 1940, with its principal place

of business at 555 International Way, Springfield, Oregon, 97477. Respondent's National Association of Insurance Commissioners Number is 54976. Respondent's Oregon license number is 953431.

Improper Denials of Timely Claims

2. On September 4, 2019, the Division received a complaint from a consumer who had been denied coverage under a health benefit plan offered by Respondent. In its letter notifying the consumer of the denial, Respondent explained the reason for the denial as "The claim is older than one year. According to your insurance policy, claims must be submitted within a year." The claims at issue in the complaint had originally been paid by another insurer but that insurer later requested a refund of its payment.[1]

3. On or around October 7, 2019, the Division began an investigation into Respondent's handling of claims that it receives more than one year after the underlying health care item or service is provided. As part of its investigation, the Division requested information about all of the commercially insured Oregon health care claims that Respondent denied between January 1, 2017 and October 1, 2019 on the basis that the claim was more than one year old.

4. Between January 1, 2017 and October 1, 2019, Respondent denied 60 claims made under a health benefit plan on the basis that the claim was more than one year old even though a different insurer had denied the claims, in whole or in part, within the prior twelve months.

5. For each of the 60 claims described in Paragraph 4, Respondent received information along with the claim demonstrating that another insurer had denied the claim, in whole or in part, within the prior twelve months.

6. Between January 1, 2017 and October 1, 2019, Respondent denied 14 claims

[1] When Respondent received documentation of an erroneous overpayment by another insurer in the course of the consumer complaint process, it reprocessed this claim and paid the consumer's eligible claims.

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made under a health benefit plan on the basis that the claim was more than one year old even though a different insurer had requested a refund of an erroneous payment made on the claim within the prior twelve months.

7. For each of the 14 claims described in Paragraph 6, Respondent received information along with the claim demonstrating that another insurer had requested a refund of an erroneous payment on the claim within the prior twelve months.

Failure to Pay Interest

8. In March of 2020, Respondent reprocessed 74 health care claims that it had previously denied as untimely and paid approximately $111,919.22 in insurance benefits to Oregon health care providers. Respondent did not include interest with any of the payments made on any of these reprocessed claims.[2]

9. In December 2020, in response to a request by the Division, Respondent determined that approximately 18 of the claims that Respondent had reprocessed and paid in March of 2020 should have included interest payments. Respondent paid the interest due on these 18 claims on or around December 30, 2020.

10. On February 2, 2021, Respondent notified the Division that it determined it needed to "update the interest component of [its] Facets claim processing system to calculate and pay applicable interest on adjusted (reprocessed) claims in accordance with ORS 743B.450 and 743B.452." Specifically, Respondent's Facet's claim processing system was not set up to pay interest on claims subject to ORS 743B.453. Respondent completed the necessary updates to its claims processing system and the changes went into effect on February 1, 2021.

11. On February 4, 2021, the Division instructed Respondent to perform an audit

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[2] In an April 30, 2021 letter, Respondent asserted that its adjustment resulted from a "good faith interpretation" of the requirements of the prompt payment, interest, and underpayment of claims statutes. Respondent further stated that "there was no intention to suppress the payment of interest incorrectly."

of all health benefit plan claims that it had reprocessed between January 1, 2018 to February 1, 2021 to determine the total number of reprocessed claims for which interest was due but not paid and the total amount of interest owed for that period.

12. On April 30, 2021, Respondent reported the results of the audit described in Paragraph 11. For the period of January 1, 2018 to February 1, 2021, Respondent determined that it owed approximately $93,729.06, on a total of 5,561 claims, in interest to health care providers, with the final amount to be determined based on the date of payment. Respondent paid interest to health care providers for the 5,561 claims at issue no later than May 31, 2021.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

Cease and Desist

13. Pursuant to ORS 731.252(1), whenever the Director has reason to believe that any person has been engaged or is engaging or is about to engage in any violation of the Insurance Code, the Director may issue an order to discontinue or desist from such violation or threatened violation.

Improper Denials of Timely Claims

14. Pursuant to ORS 743B.453(2)(a), a health insurer may not consider a health care provider's claim untimely if the claim is made no later than 12 months after a different insurer denied the claim in whole or in part.

15. Respondent violated ORS 743B.453(2)(a) on 60 occasions by denying the claims described in Paragraph 4.

16. Pursuant to ORS 743B.453(2)(b), a health insurer may not consider a health care provider's claim untimely if the claim is made no later than 12 months after a different insurer requested a refund of an erroneous payment made on the claim.

17. Respondent violated ORS 743B.453(2)(b) on 14 occasions by denying the

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claims described in Paragraph 6.

Failure to Pay Interest

18. Pursuant to ORS 743B.452(1), an insurer that fails to pay a claim to a provider within the timelines established in ORS 743B.450 shall pay simple interest of 12 percent per annum on the unpaid amount of the claim that is due and owing, accruing from the date after the payment was due until the claim is paid.

19. Pursuant to ORS 743B.452(2), interest payments required under 743B.452(1) are payable with the payment of the claim.

20. Respondent violated ORS 743B.452(2) on 5,561 occasions by failing to pay the interest required under ORS 743B.452(1) at the time that payment was made on a reprocessed claim, as described in Paragraph 12.

ORDERS

The Director issues the following ORDERS:

21. As authorized by ORS 731.252(1), the Director ORDERS Respondent to CEASE AND DESIST from violating ORS 743B.453(2)(a), ORS 743B.453(2)(b), and ORS 743B.452(2).

22. Based upon the foregoing and in accordance with ORS 731.988(1), the Director ORDERS Respondent pay a CIVIL PENALTY of $114,000 as follows:

A. A CIVIL PENALTY of $60,000 for 60 violations of ORS 743B.453(2)(a) as described in Paragraph 15 above.

B. A CIVIL PENALTY of $14,000 for 14 violations of ORS 743B.453(2)(b) as described in Paragraph 17 above.

C. A CIVIL PENALTY of $40,000 for 5,561 violations of ORS 743B.452(2) as described in Paragraph 20 above.

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23. The $114,000 CIVIL PENALTY assessed above is due and payable at the time this Order is returned to the Division.

SO ORDERED this 26th day of May, 2022.

ANDREW R. STOLFI, Director
Department of Consumer and Business Services

/s/ *Dorothy Bean*
Dorothy Bean, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, Kenneth Provencher, state that I am an officer of PacificSource Health Plans and I am authorized to act on its behalf. I have read the foregoing Consent Order, and I know and fully understand the contents hereof. I have been advised of the right to a hearing and of the right to be represented by counsel in this matter. PacificSource Health Plans voluntarily and without any force or duress consents to the entry of this Consent Order expressly waiving any right to a hearing in this matter. PacificSource Health Plans understands that the Director reserves the right to take further actions to enforce this Consent Order or to take appropriate action upon discovery of other violations of the Insurance Code. PacificSource Health Plans will fully comply with the terms and conditions stated herein.

PacificSource Health Plans understands that this Consent Order is a public document.

/s/ *Kenneth P. Provencher*
Signature

Kenneth P. Provencher
Printed name

President and CEO
Office held

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ACKNOWLEDGMENT

There appeared before me this 9th day of May, 2022, Kenneth Provencher, who was first duly sworn on oath, and stated that they were and are an officer of PacificSource Health Plans and that they are authorized and empowered to sign this Consent to Entry of Order on behalf of PacificSource Health Plans and to bind PacificSource Health Plans to the terms hereof.

/s/ *Linda Anne Martin*
Signature of Notary Public

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